DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

IL 10-2008-001
In Reply Refer To: 116

January 2, 2008

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

PROCEDURES FOR ASSESSING SUSPECTED ALCOHOL INTOXICATION AND BEHAVIOR RISK INCLUDING USE OF BREATHALYZERS

1. Purpose. This Information Letter identifies indications and procedures for assessing suspected alcohol intoxication including the use of breathalyzers and tests of blood alcohol levels for purposes of medical treatment. This Information Letter is not intended to provide guidance regarding the use of breathalyzers and blood alcohol tests for any other purpose.

2. Background

a. Having readily available means to assess alcohol intoxication is of special concern to VHA for ensuring appropriate clinical care and promoting patient safety.

b. In evaluating intoxicated patients, care must be used to establish and promote a clinical relationship of trust and compassion that may provide an opportunity to engage the patient in further clinical assessment and appropriate follow-up with clinical services that may include specialty treatment for substance use disorder.

c. Patient well-being needs to be the guiding factor in assessment of acute intoxication, which may involve requesting breathalyzer or blood alcohol levels.

d. Breathalyzer or blood alcohol test may be used with the patient's informed consent to aid in making this determination in the non-acute setting such as a Community-based Outpatient Clinic (CBOC) or substance abuse clinic. Department of Veterans Affairs (VA) regulation Title 38 Code of Federal Regulations (CFR) 17.32(d) provides that signature consent would not be required. The breathalyzer and blood alcohol test results are made part of the electronic medical record.

e. Breathalyzer or blood test results need to be used as adjunctive tools of assessment to identify the best treatment option or the best treatment program, for the patient. Breathalyzer or blood alcohol tests are not used to deny treatment, but to identify the best treatment option.

f. Breathalyzers need to be calibrated by biomedical engineering consistent with manufacturer specifications. When properly calibrated and used by trained clinicians, the breathalyzer provides a rapid preliminary estimate of blood alcohol levels, which can be

important in providing safe and effective care. All personnel operating breathalyzers need to have documented annual competency assessments for carrying out this procedure.

g. When available in a timely manner, blood alcohol levels provide the most accurate confirmation of intoxication.

h. In medical emergencies, the patient's consent is implied by law. The practitioner may provide necessary medical care, including testing for blood alcohol levels without the consent of the patient, or a surrogate's express consent, when all of the following conditions are met:

(1) Immediate medical care is necessary to preserve life or avert serious impairment of the health of the patient;

(2) The patient is unable to consent and the patient has no surrogate; or the practitioner determines that waiting for the patient's surrogate would increase the hazard to the life or health of the patient. See VHA Handbook 1004.1, VHA Informed Consent for Clinical Treatment and Procedures.

j. VA has detailed clinical guidance related to the screening, assessment, treatment, and monitoring of alcohol use. The VHA Performance Measure, Screening for Alcohol Misuse with the AUDIT- C in Primary Care, is the standard for how patients are screened routinely for alcohol misuse. The VHA-Department of Defense (DOD) Clinical Practice Guideline (CPG) for the Management of Substance Use Disorders in the Primary and Specialty Care Settings needs to be followed for management of intoxication.

3. Definition of an Intoxicated Patient. The patient has:

a. Recent ingestion of alcohol associated with a breath alcohol or blood alcohol level greater than 0.08, or associated with suggestive signs or symptoms indicating intoxication.

b. Clinically significant behavior or psychological changes related to intoxication may include:

(1) Inappropriate or aggressive behavior, mood lability, or impaired judgment.

(2) One or more of the following signs:

(a) Alcohol on breath,

(b) Slow, slurred speech,

(c) Incoordination,

(d) Unsteady gait,

(e) Nystagmus,

(f) Impairment in attention or memory, and

(g) Stupor or coma.

(3) Symptoms are not due to general medical condition or another mental disorder.

4. Recommendations for VA Medical Centers. It is recommended that each facility take the following steps:

a. In emergency departments, urgent care clinics, outpatient clinics, and inpatient or residential settings, local policy needs to be developed for the evaluation of a patient for intoxication when impairment from alcohol is suspected.

b. Both blood alcohol testing and breathalyzer testing are acceptable methods for screening in this setting.

c. Local policies need to require obtaining informed consent except in the case of a medical emergency.

5. Special Considerations

a. **Motor Vehicle Operation**

(1) When an intoxicated patient (breath alcohol or blood alcohol greater than the local legal limit (typically.08) or showing clinically significant behavioral signs of intoxication) verbally or nonverbally demonstrates intent to operate a motor vehicle, attempts need to be made to persuade (or assist) the patient to arrange other transportation or remain for extended observation until additional testing shows the level has dropped below the local legal limit and the patient is not showing signs of impairment.

(2) If the patient refuses the breathalyzer or blood test or is unwilling to remain for extended observation, the patient may not be held against his or her will by clinical staff. It needs to be documented in the medical record, with a witness if possible, that the patient was informed of any safety concerns and advised not to operate a motor vehicle. If the patient refuses to make other arrangements or to remain for observation until no longer intoxicated, the patient needs to be informed that police will be contacted due to concerns related to public safety.

(3) With VA Regional Counsel review, procedures and plans should be established to contact VA police and/or local law enforcement officials for patients leaving against medical advice if patients are considered a danger to themselves or others. These plans must take into consideration the laws governing the release of information about the veteran's medical condition. For example, when calling police, the patient should not be described as intoxicated. Instead, the patient could be described as impaired or incapable of driving. No information that is protected by Title 38 United States Code (U.S.C.) 7332 (i.e., information related to the

condition of sickle cell anemia or HIV, or the condition and treatment of drug and/or alcohol abuse) may be disclosed.

b. **Disclosure of Patient Information.** VA policy regarding disclosing patient alcohol information to police, is found in VHA Handbook 1605. It states:

(1) Requests by law enforcement officers or government officials for the taking of a blood sample from patients at VA health care facilities for analysis to determine the alcohol content must be denied. In these situations, the requester must be advised that VA personnel do not have authority to withdraw blood from a patient, with or without their authorization, for the purpose of releasing it to anyone for determination as to its alcohol content.

(2) If a blood alcohol analysis is conducted for treatment purposes, then these results may be released with the proper legal authority. The patient's signed written authorization may be obtained or the law enforcement entity may submit a written request that complies with VHA Handbook 1605.1. Prior to releasing any blood or alcohol information, in response to a valid written request from a civil or criminal law enforcement entity that is made under VHA Handbook 1605.1 the facility needs to carefully determine whether this information is protected by 38 U.S.C. 7332 (i.e., testing was done as part of a drug, alcohol, sickle cell anemia, and/or HIV treatment regimen, including offering treatment in conjunction with administration of the test). If so protected, then the provisions in VHA Handbook 1605.1. Authorization content requirements for HIV, Sickle Cell Anemia, Drug and Alcohol Information, must be followed.

(3) VA medical personnel have no authority to conduct chemical testing on patients for law enforcement purposes. However, VA personnel need not deny access to VA patients to State and local authorities who, in the performance of their lawful duties, seek to conduct blood alcohol or breath analysis tests (or other similar tests) for investigative or law enforcement purposes, unless the conduct of such tests would create a life-threatening situation for the patient. VA personnel should not assist State or local law enforcement officials in the performance of police functions that are outside the official's authority. In every case where the authority of the law enforcement official is unclear, Regional Counsel needs to be contacted for guidance.

NOTE: *Any disclosure of information to local authorities or local law enforcement entities must be accounted for in accordance with VHA Handbook 1605.1 paragraph 35c.*

6. Clinical Case Examples

a. **Case#1.** A male patient is brought to the VA Medical Center Emergency Department for evaluation of altered mental status. The patient is short of breath, delirious, and his vital signs are markedly unstable. The patient is unable to consent, no surrogate is available and immediate medical care is considered necessary to preserve life or avert serious impairment.

(1) As part of the clinical assessment, testing is performed for acetaminophen, aspirin, alcohol and specific drugs as indicated. This testing does not require the informed consent of the patient (or authorized surrogate) because the medical exception for informed consent in medical emergencies applies to this case.

(2) Under only certain circumstances may this information be released to another agency without a written authorization from the patient or the patient's authorized surrogate. The facility Privacy Officer needs to be contacted for assistance in determining if information may be released.

b. **Case #2.** A male patient drives to the Emergency Department or Urgent Care Clinic complaining of foot pain after a fall. He is apparently intoxicated and sustained some abrasions to his face and head. He consents to having blood drawn for evaluation, including a blood alcohol level. He refuses any x-ray or CT scans with the exception of an x-ray of his foot, which he states is his only problem. This is accomplished and a blood alcohol level of .24 is discovered. His foot x-ray is normal.

(1) He is advised about the blood alcohol level and asked to remain in the Emergency Department until he is no longer intoxicated. He is also given the option of calling someone to come pick him up to give him a ride home. Provisions are made for the safety of his vehicle until he can pick it up the next day.

(2) The patient refuses to stay and indicates that he is going to drive home. The providers explain to the patient the significance of his intention to drive while impaired and he is informed that the VA police will be notified if he insists on driving in this state. The patient's condition should not be referred to as intoxicated or under the influence to the VA police, but as impaired or incapable of operating a motor vehicle. This is done with a witness present to provide additional documentation of the discussion in the medical record.

(3) The VA police follow local procedures and plans in existence for patients presenting to VA medical centers under the influence of alcohol.

c. **Case #3.** A female patient presents to a CBOC for her scheduled appointment. She arrives and exhibits signs consistent with impairment from drugs or alcohol. She has the smell of alcohol on his breath. She initially denies alcohol use, is asked to submit to a breathalyzer test and this test confirms an alcohol level of .19.

(1) Following the test, the patient admits to drinking this AM. She is somewhat combative, but is able to be calmed down. She is seen by her provider and arrangements are made for her evaluation at a specialty clinic for treatment of substance use disorder.

(2). The patient insists that she can drive to the appointment. She is informed, in the presence of a witness that this is not acceptable due to her condition, and she is advised against driving. She is also advised that if she indicates she is going to operate a motor vehicle in this condition, the local police will be advised. This is all documented in the record.

(3) If she cooperates, staff needs to arrange a ride home, provide the patient with written documentation that an appointment has been made in the specialty clinic, and alert the primary care team to have someone call in a few days to see that the patient made her follow-up specialty

appointment. If the veteran is not cooperative, the local authorities are notified and they will follow their protocols according to the situation they find when they encounter the patient.

h. If the patient refuses the breathalyzer test, the procedure for advisement and notification of local authorities would be the same. In cases of reasonable suspicion, based on clinical evidence of impairment, this course is warranted.

7. References

a. VHA Handbook 1004.1 VHA Informed Consent for Clinical Treatments and Procedures Policy (http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=404)

b. Title 38 CFR 17.32(d) Medical : Informed Consent – Extension of Time period and Modification of Witness Requirement for Signature Consent.

c. VHA Performance Measure, Screening for Alcohol Misuse with the AUDIT-C in Primary Care. Measure 12a.1 at:
http://vaww.oqp.med.va.gov/oqp_services/performance_measurement/tech_man.asp#TablesTM

d. VHA-DOD Clinical Practice Guideline, Management of Substance Use Disorders in Primary and Secondary Care Settings at: (http://www.oqp.med.va.gov/cpg/SUD/SUD_Base.htm)

e. VHA Handbook 1605.1, Privacy and Release of Information.

8. Contact: Questions may be addressed to the Office of Patient Care Services' Office of Mental Health Services, at (202) 461-7350.

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Under Secretary for Health

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